



# Patient Information Sheet

Chart # \_\_\_\_\_ Office Location \_\_\_\_\_ Date \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Middle Int. \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mother's Maiden Name: \_\_\_\_\_ Do you:  Rent  Own Do you have a Credit/ Debit Card:  Yes  No  
 Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_ Sex: (M) (F)  
 E-Mail address: \_\_\_\_\_ DL/ ID # \_\_\_\_\_ State: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ How Long: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ Work Phone Number: ( ) \_\_\_\_\_ Ext.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 In Case of Emergency, contact: (Name) \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_  
 Relationship: \_\_\_\_\_

How do you intend to pay?  Cash  Credit  Insurance  Medi-Cal  Other \_\_\_\_\_

## Responsible Party

Relationship to Patient: \_\_\_\_\_

(Disregard if same as above)

First Name: \_\_\_\_\_ Middle Int. \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mother's Maiden Name: \_\_\_\_\_ Do you:  Rent  Own Do you have a Credit/ Debit Card:  Yes  No  
 Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_ Sex: (M) (F)  
 E-Mail address: \_\_\_\_\_ DL/ ID # \_\_\_\_\_ State: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ How Long: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ Work Phone Number: ( ) \_\_\_\_\_ Ext.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How do you intend to pay?  Cash  Credit  Insurance  Medi-Cal  Other \_\_\_\_\_

## Personal References

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone Number: ( ) \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone Number: ( ) \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Primary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insured Address: \_\_\_\_\_  
 Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer's Phone Number ( ) \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone Number of Insurance Co.: ( ) \_\_\_\_\_  
 Name of Union and Local Union Number \_\_\_\_\_

## Secondary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insured Address: \_\_\_\_\_  
 Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer's Phone Number ( ) \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone Number of Insurance Co.: ( ) \_\_\_\_\_  
 Name of Union and Local Union Number \_\_\_\_\_

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.  
**I am aware that by signing below I certify that all information is complete and correct. Western Dental Of Arizona, Inc., or its agents may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for Western Dental Of Arizona, Inc., or its agents to verify credit history.**

Signature of Patient

Signature of Responsible Party

## For Office Use Only

VRU Code: \_\_\_\_\_ Date: \_\_\_\_\_ VRU Code: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Form 40A-AZ (01/09)

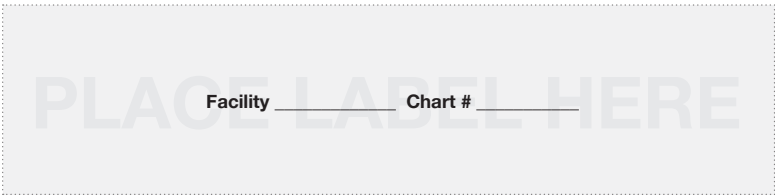
# HEALTH HISTORY

DATE \_\_\_\_-\_\_\_\_-\_\_\_\_ PATIENT NAME \_\_\_\_\_

AGE \_\_\_\_\_ SEX M / F HEIGHT \_\_\_\_\_ WEIGHT LBS. \_\_\_\_\_

In case of an emergency, contact (person) \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_



## INSTRUCTIONS:

Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential.

<p><b>Why</b> are you here today? _____</p> <p><b>When</b> was your last visit to a dental office? ____/____/____</p> <p>PRIOR DENTIST'S NAME and PHONE NUMBER: _____ (____) _____</p>	<p><b>When</b> were your last dental x-rays taken? ____/____/____</p> <p>Are those x-rays available? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>1. Are you in poor health? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you had any serious illness, an operation, or hospitalization in the last 5 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what was the problem? _____</p> <p>3. Are you pregnant? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies, hives or a skin rash? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you allergic to latex or rubber products? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you have any blood disorder such as anemia? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth, head or neck? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you have or are you being treated for tuberculosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do any of your teeth hurt? Which ones? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Do you wear a partial denture or any other removable dental appliance? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>1. Has there been any change in your general health within the past year? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are you currently under the care of a physician? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No A. If so, what is the condition being treated _____</p> <p>3. The name and address of my physician is _____ _____ _____</p> <p>4. Do you have or have you had any of the following diseases or problems:</p> <p>A. Damaged heart valves or artificial heart valves ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Congenital heart lesions or murmurs ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, or other) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>1) Do you have pain in your chest upon exertion? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Are you ever short of breath after mild exercise? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Do your ankles swell? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5) Do you have a cardiac pacemaker? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Low blood pressure ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Sinus trouble ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. Asthma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>G. Emphysema or respiratory problems ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>H. Persistent cough or cough up blood ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I. Fainting spells or seizures ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>J. Diabetes ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>1) Do you urinate (pass water) more than 6 times a day? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Are you thirsty much of the time? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Does your mouth frequently become dry? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>K. Kidney trouble ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>L. Stomach troubles/ulcers ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>M. Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>N. Sexually transmitted disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>O. HIV/AIDS ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>P. Herpes ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Q. Arthritis or painful, swollen joints ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>R. Do you have a prosthetic hip <input type="checkbox"/> joint prosthesis <input type="checkbox"/> implants <input type="checkbox"/> bone plates <input type="checkbox"/> or screws <input type="checkbox"/> other _____</p> <p>5. Have you had abnormal bleeding associated with previous surgery, trauma or dental extractions? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A. Do you bruise easily? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Have you ever required a blood transfusion? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If so, explain the circumstances _____</p> <p>6. Do you use or have you used any of the following:</p> <p>1. Tobacco: smoke ____ smokeless (chewing) ____ ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Quantity per day _____</p> <p>2. Alcohol ____ Quantity per day ____ ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Recreational drugs ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>7. Have you taken the diet medication Redux® (Fen-Phen)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you taking any medications ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate which. Antibiotics or sulfa drugs <input type="checkbox"/> Anticoagulants (blood thinners) <input type="checkbox"/> Medicine for high blood pressure <input type="checkbox"/> Cortisone (steroids) <input type="checkbox"/> Antidepressants <input type="checkbox"/> Sedatives <input type="checkbox"/> Antihistamines <input type="checkbox"/> Aspirin <input type="checkbox"/> Insulin, tolbutamide (orinase) or similar drug <input type="checkbox"/> Digitalis or drugs for heart trouble <input type="checkbox"/> Nitroglycerin <input type="checkbox"/> Oral contraceptives or other hormonal therapy <input type="checkbox"/> Medications to treat osteoporosis such as Fosamax, Aredia, Boniva, Zometa (Bisphosphonates) <input type="checkbox"/> Herbal remedies <input type="checkbox"/> Any other drug or medicine _____</p> <p>9. Are you allergic or have you reacted adversely to any of the following:</p> <p>Local anesthetics ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or other antibiotics ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa drugs ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates, sedatives or sleeping pills ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Codeine or other narcotics ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nickel or other metals ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other allergies ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Are you wearing contact lenses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Do you have any problems associated with your menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Are you nursing? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>DENTAL HISTORY :</b></p> <p>14. Is there anything about your teeth or smile that you would like to change? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If so, explain _____</p> <p>15. Have you had any serious trouble associated with any previous dental treatment? If so, explain _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. How often do you brush your teeth? ____ When? ____</p> <p>17. How often do you floss? ____ When? ____</p> <p>18. Do your gums bleed or hurt? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Are any of your teeth sensitive to: Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Pressure <input type="checkbox"/> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Does food get caught in your teeth? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Do you have frequent headaches <input type="checkbox"/> neck aches <input type="checkbox"/> or shoulder aches? <input type="checkbox"/> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you clench or grind your teeth? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Have you experienced any pain or soreness in the muscles of your face or around your ear? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Does your jaw click or pop? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Do you wear any type of denture or partial denture? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A. Date of placement ____ / ____ / ____</p> <p>B. Is there anything about the denture that you would like to change? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

FOLLOW UP to Medical History by DENTIST ONLY \_\_\_\_\_

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

SIGNATURE OF PATIENT or Guardian if patient is a minor \_\_\_\_\_ DATE \_\_\_\_-\_\_\_\_-\_\_\_\_

SIGNATURE OF DENTIST \_\_\_\_\_ DATE \_\_\_\_-\_\_\_\_-\_\_\_\_

UPDATE	DATE	COMMENTS	DR. SIGNATURE	EMPLOYEE#	PATIENT SIGNATURE



Patient Name: \_\_\_\_\_ Chart No.: \_\_\_\_\_ Office No.: \_\_\_\_\_

**NOTICE TO INSURANCE PATIENTS**

I understand that I am responsible for my balance with Western Dental, including under the following circumstances:

- A. The treatment goes over my insurance company's yearly maximum benefit.
- B. My insurance company denies treatment.
- C. I am not eligible for insurance.
- D. The insurance benefits are less than what was indicated on Western Dental's Estimator.
- E. I prevent or delay payment by not complying with requests for insurance forms and signatures.
- F. I do not complete my treatment and it results in non-payment by my insurance company.
- G. Lab costs are incurred due to my failure to appear at my appointments.
- H. I RECEIVE MY INSURANCE CHECK AND DO NOT SEND IT TO WESTERN DENTAL.**

I HAVE READ AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient or Responsible Party)

\_\_\_\_\_  
(Print Patient or Responsible Party's Name)

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Western Dental Employee)

\_\_\_\_\_  
(Print Employee Name and Employee Number)



## JOINT NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**This Notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.**

If you have any questions about this Notice, complaints, or should you need to contact Western's Privacy Officer to comply with any provision of this Notice, please contact: Western's Privacy Officer, C/o Western Dental Of Arizona, Inc., P.O. Box 14227, Orange, CA 92863, Phone: (800) 417-4444. E-mail: PrivacyOfficer@WesternDental.com

*Organizations covered by Joint Notice:*

Western Dental Of Arizona, Inc.

Permier Choice Dental, Inc.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**For Treatment** We may use your health information to provide you with medical treatment or services. We may disclose health information about you to doctors, dental assistants, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be performing a tooth extraction and may need to know if you have other health problems that could complicate your treatment. The doctor may use your health history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

**For Payment** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

**For Health Care Operations** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

**Appointment Reminders** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

**Treatment Alternatives** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Products and Services** We may tell you about health-related products or services that may be of interest to you.

### SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required By Law** We will disclose health information about you when required to do so by federal, state or local law. For example, Western Dental may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victim of abuse, neglect or domestic violence; and,
- To assist law enforcement officials in their law enforcement duties.

**Research** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

**Organ and Tissue Donation** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

**Military, Veterans, National Security and Intelligence** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation** We may release health information about you in order to comply with the law and regulations related to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

(See other side)

**Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**Law Enforcement** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Coroners, Medical Examiners and Funeral Directors** We may release health information to a coroner or medical examiner to enable them to carry out their lawful duties. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Information Not Personally Identifiable** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Family and Friends** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

## OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy** You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Western's Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**Right to Amend** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Dental Record Amendment/Correction Form to Western's Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

**Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to Western's Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

**We are Not Required to Agree to Your Request** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical Information* to Western's Privacy Officer.

**Right to Request Confidential Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* to Western's Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner and mail a copy to you.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Western's Privacy Officer. You will not be penalized for filing a complaint.



# ARBITRATION AGREEMENT

## WAIVER OF RIGHT TO JURY TRIAL

Patient Chart No. \_\_\_\_\_

Patient Name: \_\_\_\_\_

Office Location: \_\_\_\_\_

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. **Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.**

**Article 2: All Claims Must Be Arbitrated:** It is the intention and agreement of the parties that this arbitration agreement shall cover **all claims or controversies** relating to the matters described in Article 1 above, except claims within the exclusive jurisdiction of the Arizona Justice Courts, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Western Dental of Arizona, Inc. ("Western") or any employee or agent or providers of Western, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person.

The reference to Western includes the corporation, and its employees, agents and providers. Filing any action in any court by Western to collect any fee from Patient shall not waive the right to compel arbitration of any claim described in Article 1. However, following the assertion of any claim against Western, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

**Article 3: Procedures and Applicable Law:** Patient shall initiate arbitration by serving a Demand for Arbitration on Western and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: General Counsel, Western Dental, 530 S. Main Street, Suite 600, Orange, CA 92868. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and Western agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conducted by the American Arbitration Association.). Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Arizona Revised Statute §§ 12.1501 et. seq., Arizona law and procedures, and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

**Article 4: Retroactive Effect:** Patient intends this Contract to cover services rendered by Western not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

**Article 5: Severability:** If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

\_\_\_\_\_  
Print Patient's Name (Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient) Dated: \_\_\_\_\_, 20 \_\_\_\_\_

### WESTERN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, Western likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 3 above.

\_\_\_\_\_  
Prepared By Western Employee Print Name Date Signed

A signed copy of this document is to be given to Patient. The Original is to be filed in Patient's dental chart.



Dear Patient,

In keeping with the standards of the profession and the recent developments in sterilization and infection control, we at Western Dental have formulated this general public information bulletin to give our patients an idea of how seriously we take the safety and well being of our patients.

- 1) All doctors, hygienists and assistants wear gloves, masks, and face shields or goggles.
- 2) Doctors and assistants wash their hands and change gloves with every patient.
- 3) Dental drill handpieces are cleaned, bagged and sterilized prior to use on each patient.
- 4) All instruments are scrubbed, cleaned, bagged and sterilized according to guidelines set forth by the Center for Disease Control & Prevention.
- 5) All instruments are sterilized in autoclaves or chemical vapor sterilizers according to recommended procedures. If the instruments are heat sensitive, an overnight (10 + hours) sterilized soak is done.
- 6) Western Dental test all sterilizers weekly and this is confirmed through independent lab analysis.
- 7) All operating surfaces are cleaned with EPA registered hospital grade surface disinfectants.
- 8) Many disposable items are used. Once used, they are discarded. Some examples are the injection needles, plastic suction tips and the polishing cups.
- 9) An independent company has been retained to vaccinate and test our staff for the Hepatitis B virus.
- 10) Our staff, while taking x-rays, always use fresh gloves and each x-ray holder is individually bagged and sterilized.
- 11) Infection control seminars are held for all our dental offices throughout the year.
- 12) Our company has retained an infection control consultant who randomly inspects our offices on a routine basis. Many of these inspections are done on a "surprise" basis to ensure that the offices are following accepted guidelines. In addition to these inspections, our own administrative staff performs regularly scheduled audits on all our offices.

Western Dental provides dental care services without discrimination based on race, religion, color, national origin, sex, sexual orientation, physical or mental disability, age or marital status and protects the privacy of each of its patients. If any questions or concerns arise regarding the dental care, treatment or services you have received, contact Western Dental Of Arizona Inc. at 1-800-992-3366 or write the Western Dental Of Arizona, Inc., P.O. Box 14227, Orange, California, 92863.



### HOW DID YOU HEAR OF US ?

• PLEASE CHECK ONE BOX ONLY !

NAME \_\_\_\_\_

ZIP CODE \_\_\_\_\_

OFFICE \_\_\_\_\_

DATE \_\_\_\_\_

- A.  SPANISH T.V.
- B.  ENGLISH T.V.
- C.  SPANISH RADIO
- D.  ENGLISH RADIO
- E.  FLYER / MAILER / COUPON
- F.  NEWSPAPER / MAGAZINE
- G.  SPANISH YELLOW PAGES
- H.  ENGLISH YELLOW PAGES
- I.  BILLBOARD / BUS SIGN
- J.  BUILDING LOCATION SIGN

- K.  FRIEND / NEIGHBOR / RELATIVE
- L.  TELEPHONE / LETTER / RECALL
- M.  DENTAL PLAN REFERRAL
- N.  MANAGED CARE - (GMC, ETC.)
- O.  W.D. VAN 1-800-844-4444
- P.  W.D. BOOTH (SWAPMEET, SPECIAL EVENT, ETC.)
- Q.  INTERNET
- R.  **W.D. DENTIST**
- S.  **W.D. ORTHODONTIST**

Form 232 (Rev. 11/08)



### ¿CÓMO ENCONTRÓ INFORMACIÓN SOBRE NUESTRO CONSULTORIO?

¡POR FAVOR, MARQUE UN CUADRO SOLAMENTE!

NOMBRE \_\_\_\_\_

ZONA \_\_\_\_\_

OFICINA \_\_\_\_\_

FECHA \_\_\_\_\_

- A.  TELEVISIÓN EN ESPAÑOL
- B.  TELEVISIÓN EN INGLÉS
- C.  RADIO EN ESPAÑOL
- D.  RADIO EN INGLÉS
- E.  VOLANTES/AVISOS POR CORREO/CUPONES
- F.  PERIÓDICO/REVISTA
- G.  GUÍA TELEFÓNICA EN ESPAÑOL
- H.  GUÍA TELEFÓNICA EN INGLÉS
- I.  CARTELERA/ANUNCIO EN EL AUTOBÚS
- J.  CARTEL EN UN EDIFICIO

- K.  AMIGOS/VECINOS/PARIENTES
- L.  TELÉFONO/CARTA/RECORDATORIO
- M.  REFERENCIA POR PARTE DE UN PLAN DENTAL
- N.  ATENCIÓN COORDINADA (GMC, ETC.)
- O.  CAMIONETA DE WESTERN DENTAL 1-800-844-4444
- P.  QUIOSCO DE WESTERN DENTAL (FERIAS AL ESTILO "SWAPMEET", ALGÚN EVENTO ESPECIAL, ETC.)
- Q.  INTERNET
- R.  **UN DENTISTA DE WESTERN DENTAL**
- S.  **UN ORTODONCISTA DE WESTERN DENTAL**

